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SUBJECT: Development in the face of the economic crisis: An opportunity for reforming US foreign assistance in Africa and global health

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Background

Thank you for this opportunity to discuss global health and gender in Africa. My name is Meredeth Turshen, and I am a Professor at the E.J. Bloustein School of Planning and Public Policy at Rutgers, the State University of New Jersey, in New Brunswick, NJ. Previously, I worked in the United Nations system for twelve years, at UNICEF and the World Health Organization. I started my teaching career at Howard University, and I have been at Rutgers since 1982. I am author and editor of nine books; the two most relevant titles for today's hearing are *Privatizing Health Services in Africa* and *Women's Health Movements: a Global Force for Change*. For five years I co-chaired the Association of Concerned Africa Scholars, and I am a founding editor of the *Review of African Political Economy*.

The title of these hearings appropriately links economic policy to health issues. The prevailing neoliberal economic model (also known as the Washington Consensus) mandates macroeconomic parameters, which the international financial institutions have implemented through their loan programs. These constraints include ceilings on government expenditures on health and education (cutting services and personnel and eliminating food subsidies, among others), trade liberalization policies that hurt weaker domestic industries in African countries, and World Trade Organization regulation of private property rights in medicines (impeding access to affordable drugs, among others). The U.S. Government has imposed many of the same conditions through bilateral trade and investment agreements. Applying these economic policies over the past twenty years, international institutions, multinational corporations and bilateral agreements have

transformed global health care and devastated public health services by commercializing both supply of and expenditure on health services.

Nobel laureate Joseph Stiglitz has said that the theories that guide the Washington Consensus are empirically flawed, a blend of ideology and bad science. The neoliberal approach seeks to minimize the role of government and relies upon trickle-down economics to address poverty, believing that growth and wealth will trickle down to all segments of society. Stiglitz asserts that these policies have led to the current economic crisis, which may throw as many as 200 million additional people into poverty. Fortunately, as the title of this hearing suggests, the economic crisis is an opportunity for reform.

In this testimony I will address the need for reform of US foreign assistance in Africa and African health care, which for too long have been directed by the flawed policies of the Washington Consensus.

Two priorities for health care in Africa

Poverty reduction is the first priority for health care in Africa because poverty is the biggest epidemic the public health community faces there. Poverty creates ill-health when it forces people to live in environments that make them sick, without decent shelter, clean water or adequate sanitation. Environmental concerns are especially important because the UN predicts that the urbanized population in Africa will double by 2025, and more than 50 percent of Africans will live in urban areas by 2030.

Global poverty is concentrated in Sub-Saharan Africa where about 41% of the population lived on less than one dollar a day in 2007. In the last 25 years, real income has declined in Sub-Saharan Africa. (Latin America and the Arab States registered relatively modest gains, while growth was rapid in East Asia.) The IMF has just announced that is scrapping some of the stringent harmful conditionalities that have hampered poverty reduction in Africa. New poverty reduction strategies are needed that stress the right to health as a primary objective; these strategies should be based on an economic philosophy that promotes government investment in public health.

Support for fragile health systems is the second priority. President Bush's President's Emergency Plan for AIDS Relief (PEPFAR), and his President's Malaria Initiative (PMI) like other disease-centered programs have galvanized attention and brought considerable new resources, but they are being channeled through fragile, under-resourced systems. Eleven sub-Saharan African countries spend less than $5 per person per year on health; another 15 spend less than $10. The WHO Commission on Macroeconomics and Health (WHO 2001) estimated the cost of a set of essential interventions at $34 per person per year, much of which would need to be public spending, or $45 to include some additional hospital services. Africans spend more out of pocket on health care than Americans.

The fragility of African health care systems is in large part due to the failed policies of donor agencies that have undermined government health services in two ways: from

above, by using structural adjustment programs to hollow out public health systems, and from below by channeling funds to the private sector, usually through private voluntary organizations. These and other policies accelerate brain drain, which siphons health personnel from the government sector.

Brain drain takes several forms: the drift of trained African health personnel from rural to urban areas, from primary to tertiary health facilities, and from the public to the private sector within their countries; in addition personnel move from their countries to South Africa on the continent, and from African countries to Europe, Oceania, and North America. Austerity policies that cut government jobs push personnel out of public health services; and foreign aid policies that channel assistance through international nongovernmental organizations, which now number nearly one thousand in Africa, attract government personnel to the private sector, often in administrative rather than service positions. Proposed legislation, such as The Nursing Relief Act of 2009 (H. R. 1001), which would create a new nonimmigrant visa category for registered nurses, and the earlier H.R.5924 Emergency Nursing Supply Relief Act, would aggravate the effects of brain drain on fragile health systems. African countries not only sustain the loss of their trained personnel but also absorb the costs of social reproduction, nursing and medical education.

Large vertical disease-based initiatives eclipse more traditional conduits of foreign assistance by going around the United Nations and WHO, and they contribute to a decline in spending on maternal and child health, which is 22 percent less than it was ten years ago. I am attaching for the record a detailed report on what has happened to women's health in Sub-Saharan Africa since the 1994 Cairo International Conference on Population and Development (ICPD). Since 1986 the poorest African countries grew poorer while the richest nations of the North got (much) richer. Life expectancy fell in Africa. Maternal mortality rates have risen or stayed the same in 16 of 40 African countries. Skilled personnel attended fewer births in 12 of 31 countries for which comparative data are available. Public expenditure on health has stagnated in 24 of 25 countries for which there are data; the health budget has risen only on the island of Mauritius. The rates of preventable and treatable communicable diseases have risen--not only AIDS but malaria and tuberculosis as well. Ratios of physicians fell in four countries and remained the same in another four; they rose in 16 countries, but not at the rate of population growth. Family planning is the one service that grew in the decade since Cairo. Governments did not meet the 2005 goal of reducing by half the gap between the proportion of individuals using contraceptives and the proportion expressing a desire to space or limit their families. Of the key goals embodied in the ICPD Programme of Action, governments achieved only one goal: providing skilled attendants to assist 40 percent of all births where the maternal mortality rate is very high (interpreted here as over 1,000 deaths per 100,000 live births). The conclusion is that on too many fronts, especially in the areas of ICPD promises, the countries and people of sub-Saharan Africa have moved backwards or have stagnated and made no progress.

Progress towards health-related goals

The record is no better in meeting Millenium Development Goals (MDG). One in five children (20 percent) die before the age of five. 265,000 women in Sub-Saharan Africa died during pregnancy or childbirth in 2005, approximately one in 22. 25.8 million adults and children in Sub-Saharan Africa are living with HIV. 44 percent of the population still has no access to safe and clean water. Average life expectancy in Sub-Saharan Africa is 47 years. Only one third of children of primary school age now attend school.

According to the MDG Africa Steering Group report (June 2008), the continent as a whole is lagging behind on each goal. Progress towards achieving gender equality and environmental sustainability remains inadequate. The challenge of meeting the eight MDGs in African countries is compounded by the grave long-term risk that climate change poses. The MDG Africa Steering Group claims that African countries demonstrably require additional resources for adaptation since they are particularly vulnerable to the effects of climate change and the growing risk of natural disasters. The recent rise in food prices, which is related to climate change, volatile hydrocarbon prices, and commodity speculation, is putting great pressure on African economies, threatening to unravel hard-won progress in fighting hunger and malnutrition. The dangers of a decelerating world economy add to the challenges that African countries face now and in coming years.

The United States subscribes to the MDG challenge of halving extreme poverty by 2015, but it has no international poverty reduction policy, and the 2007 US Foreign Assistance Framework, which seeks to align all U.S. government foreign assistance into one cohesive structure, lacks a focus on poverty reduction. In addition to reclaiming poverty reduction as the primary goal of aid, the U.S. should target development and humanitarian assistance where need is greatest, rather than according to the national security agenda.

Changes needed in global assistance

United States net official development assistance (ODA) fell in 2007 by 9.8 percent over 2006 to $21.8 billion. The ratio of ODA to GNI also fell from 0.18 percent in 2006 to 0.16 percent in 2007. The fall was mostly due to lower levels of debt relief provided in 2007 as well a decrease in ODA to Iraq. The level of U.S. assistance—0.22 percent in 2005—is far below the foreign aid target of 0.56 percent of GDP by 2010, and 0.7 percent by 2015 that G8 members from the European Union committed to at the 31st summit in Gleneagles in 2005.

There is widespread agreement in the U.S. and abroad that the U.S. does need to change the way that it administers its health-related assistance. According to OECD (2009) the approach of the United States differs from that of other Development Assistance Committee members in that each U.S. government agency has its individual approach to planning, agreeing and implementing its assistance in consultation with the partner country. And there are twenty-six different agencies conducting aid programs. USAID,

historically the main agency for implementing U.S. programs in health, education, humanitarian relief, economic development and agriculture, has seen its share of foreign aid decline—from over 50 percent in 2002 to under 40 percent in 2005. One cause of this decline has been the increase in foreign assistance disbursements to the Department of Defense (DoD), up from 5.6 percent of the official development assistance budget in 2002 to 21.7 percent in 2005. This shift from USAID to DoD represents an undesirable blurring of the boundaries between defense, diplomacy and development. In addition to reconstruction efforts in Afghanistan and Iraq, DoD is a contractor to PEPFAR in Nigeria, work in AIDS vaccine research, and the building of schools and hospitals in Tanzania and Kenya; USAID might be better suited to carry out this work. Currently the State Department takes the leading role in AIDs interventions, and PEPFAR is located in the State Department, which has limited development expertise.

Phantom aid

One significant problem in the way global assistance is delivered is that the bulk of the money is wasted, misdirected, or recycled within donor countries. Agencies fail to target the poorest countries, spend too much on overpriced technical assistance from international consultants, and tie aid to purchases from donor countries' own firms. Only 3 percent of U.S. bilateral official development assistance to least developed countries was untied, according to OECD. In one estimate, untying U.S. assistance would have yielded an additional $4.37 billion in 2005. Planning, implementation, monitoring, and reporting requirements are cumbersome and poorly coordinated, administrative costs are excessive, and disbursements are late and partial. Many are calling this phenomenon “phantom aid”: 61 percent of aid from the United Kingdom was "phantom" rather than "real," rising to almost 90 percent in the case of France and the United States (ActionAid International 2005, 2006). When "phantom aid" is subtracted from the 0.25 percent of national income that donor countries are ostensibly spending on aid each year, the real value of foreign assistance is 0.1 percent.

The United States is participating with the OECD Development Assistance Committee to improve the effectiveness of its aid and make it more transparent and predictable. Re-engaging with the multilateral system would promote better international coordination, and untying aid would help disentangle foreign assistance from U.S. business interests. Appropriations for five to ten years would resolve problems of unpredictability. The U.S. share of ODA to multilateral organizations has fallen from 26 percent in 2002 to 8 percent in 2005. We need to renew our support of UN agencies like UNFPA and decrease the undue influence of religious doctrine on sexual and reproductive health programs.

If the U.S. Government is serious in its wish to help build public health systems in Africa, then scattered health initiatives must be consolidated and channeled through the World Health Organization. The funds in the President's Emergency Plan for AIDS Relief (PEPFAR) and the President's Malaria Initiative (PMI) should be turned over to WHO, which should once again administer AIDS programs (disbanding UNAIDS) as well as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Roll Back Malaria Campaign. The delivery of aid through private voluntary organizations (PVO) should be curtailed in favor of multilateral channels. This change would not only assist

African governments in planning their health care services and in reducing the administrative workload of overseeing hundreds of uncoordinated PVO projects, but it would also help these organizations wean themselves from dependence on government support; more independence would mean a more critical stance as advocates for their constituents. From the perspective of African people, they could hold their governments accountable for service delivery in a way they cannot with the private sector.

The Pharmaceutical Industry
Under the current international intellectual property rights regime, pharmaceuticals oligopolies hinder the supply of affordable medicines. The U.S. has pressured developing countries not to use the safeguards provided in the 2001 Doha Declaration on TRIPS, which would allow easier access to generic medicines. The U.S. also enforces tight standards of intellectual property protection through bilateral and regional trade agreements. A burdensome and inefficient system in PEPFAR programs limits access to antiretroviral drugs and approves only a small number of generic drugs.

The UNDP and the World Bank are pursuing the concept of public health as a global public good even though they fear that patients will have a "free ride" on jointly supplied public goods. I think this fear is misplaced because I believe there are no false demands for care, only unmet needs. My fear is that providers will have a "free ride" feeding at the public trough. The UNDP and the World Bank want to establish a public fund for the production of what are essentially private goods (for instance, medicines), arguing that there is insufficient private demand for the private commercial sector to respond. So for example, a public fund would give the pharmaceutical industry money for the research and development of commercial products that would address the communicable diseases common in Africa, Asia and Latin America, and specifically to develop an AIDS vaccine.

There are two problems here, apart from the ethical one, which is that one of the most profitable industries would receive additional tax breaks and subsidies, precisely the sort of aid denied to poor public health patients. The first problem is that without a strong, state-run public health service, there will be no system for the ongoing distribution of an AIDS vaccine as experience with other vaccines has shown. For example, a vaccine for neonatal tetanus was developed in 1931, but tens of thousands of African infants still die of this disease. Similarly, a vaccine for Hepatitis B is available, but vertical mass vaccination campaigns cannot supply it. Again, Africans need comprehensive public health services, not the uncoordinated provision of charity.

The second problem is that Africans cannot afford to buy the drugs and vaccines that already exist. To solve this dilemma, the World Bank proposes creating a fund to purchase vaccines and suggests that international development banks issue contingent loans for vaccine purchases. This does solve the dilemma for the pharmaceutical industry because it guarantees them sales. But instead of working to cancel the debt of African countries, the World Bank would increase African indebtedness, while doing little to increase income from primary products through fair trade arrangements.

Priorities for achieving gender equality

The first MDG deadline–to achieve gender parity in primary and secondary education by 2005–has not been met. This failure is particularly disheartening because the deadline was realistic and the goal reachable. Most countries in sub-Saharan Africa will need a significant boost in their average annual rates of enrolment in order to reach universal education by 2015. Some 37 countries, most in sub-Saharan Africa, will need to have an average annual rate of increase of over 2 percent in order to reach the goal. Not educating children has special significance in public health, both because of the high correlation of educated mothers with healthier children, and the greater provision and consumption of health services by women. There are more than five nurses and midwives for every doctor in the African region (typically more than 70 percent of doctors are males, while almost all midwives and most nurses are women).

Poverty creates competitors for girls' time in school—the pull of work (paid and unpaid) and the push to early marriage. 26 percent of African children under the age of fourteen are in the labor force. School fees—the same misguided World Bank policy that demanded user fees in health facilities—keep many poor children out of school.

Gains in enrolment are sometimes countered by high dropout rates. Apart from work and marriage, girls may drop out because there are few women teachers, or if there are female instructors, the head teachers are male. Girls drop out when classes are not relevant, if there are no role models, or if completing school fails to prepare them for meaningful employment. Textbooks may reinforce gender stereotypes, with boys depicted as active and girls as passive. Curricula often exclude girls from mathematics, science and technology, precisely the prerequisites for careers in medicine, nursing and public health. The Africa region bears more than 24 percent of the global burden of disease but has access to only 3 percent of the world's health workers.

Schools need to become more child-friendly, with safe water sources and sanitation facilities, so important to girls. Many schools fail to protect girls from violence, inflicted by teachers or older boys. Whether perpetrated by adults or children, almost all violence in schools reflects a "hidden curriculum" that promotes gender inequality and stereotyping. According to the UN World Report on Violence (2006), boys taunt each other about their lack of masculinity and harass girls with verbal and physical gestures that are sexual in nature. Corporal punishment of boys is more frequent and harsh than corporal punishment of girls, but girls suffer from sexual aggression by male teachers and boys, which is often dismissed as "just boys being boys", while girls are blamed for "asking for it".

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